FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038349

Facility Name: HERITAGE MANOR-BLOOMINGTON

Address: 700 E. WALNUT (Number) BLOOMINGTON (City) 61701 (Zip Code)

County: MCLEAN

Telephone Number: (309)827-8004 **Fax #** ( )

IDPA ID Number: 370909086003

Date of Initial License for Current Owners: 1963

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) CRAIG L. ATER
(Title) SENIOR V.P. FINANCE

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	111	Skilled (SNF)	111	40,626	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)		0	3
4		Intermediate/DD			4
5		Sheltered Care (SC)		0	5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,626	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,389	12,180	1,653	37,222	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	23,389	12,180	1,653	37,222	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 91.62%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1963

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [XX]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 1963 and days of care provided _____

Medicare Intermediary MUTUAL OF OHMAHA

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Previe

	G/L	RECAP CENSUS	DIFF
PP	13869	13869	0
IPA	23389	23389	0
medicare	1653	1653	0
	38911	38911	

IPA BEDHOLDS	0
PP BEDHOLDS	257
PP CONVERS	1432

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTO # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	228,452	19,859		248,311		248,311	2,697	251,008			1
2	Food Purchase		154,912		154,912		154,912	(783)	154,129			2
3	Housekeeping	71,996	21,606		93,602		93,602	0	93,602			3
4	Laundry	50,910	16,447		67,357		67,357	0	67,357			4
5	Heat and Other Utilities			82,682	82,682		82,682	939	83,621			5
6	Maintenance	101,651	45,729	35,110	182,490		182,490	9,542	192,032			6
7	Other (specify):*							0				7
8	**TOTAL General Services**	453,009	258,553	117,792	829,354		829,354	12,395	841,749			8
	B. Health Care and Programs											
9	Medical Director			9,900	9,900		9,900	0	9,900			9
10	Nursing and Medical Records	1,261,944	76,903	8,987	1,347,834		1,347,834	0	1,347,834			10
10a	Therapy		153,326	151,284	304,610	(335,321)	(30,711)	174,320	143,609			10a
11	Activities	62,530	2,058	0	64,588		64,588	0	64,588			11
12	Social Services	21,394	0	1,444	22,838		22,838	0	22,838			12
13	Nurse Aide Training	14,903	1,050		15,953		15,953	2,352	18,305			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,360,771	233,337	171,615	1,765,723	(335,321)	1,430,402	176,672	1,607,074			16
	C. General Administration											
17	Administrative	59,283			59,283		59,283	36,318	95,601			17
18	Directors Fees							2,756	2,756			18
19	Professional Services			336,209	336,209		336,209	(327,875)	8,334			19
20	Dues, Fees, Subscriptions & Promotions			87,428	87,428	(61,083)	26,345	(13,957)	12,388			20
21	Clerical & General Office Expense	102,029	12,789	12,985	127,803		127,803	134,338	262,141			21
22	Employee Benefits & Payroll Taxes			307,134	307,134		307,134	21,186	328,320			22
23	Inservice Training & Education			788	788		788	1,004	1,792			23
24	Travel and Seminar			6,851	6,851		6,851	(4,852)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			11,719	11,719		11,719	1,294	13,013			26
27	Other (specify):*			21,343	21,343		21,343	(21,278)	65			27
28	**TOTAL General Administration**	161,312	12,789	784,457	958,558	(61,083)	897,475	(171,066)	726,409			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,975,092	504,679	1,073,864	3,553,635	(396,404)	3,157,231	18,001	3,175,232			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTO # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			183,781	183,781		183,781	5,964	189,745			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			240,841	240,841		240,841	(803)	240,038			32
33	Real Estate Taxes			58,069	58,069		58,069	0	58,069			33
34	Rent-Facility & Grounds							2,364	2,364			34
35	Rent-Equipment & Vehicles			11,829	11,829		11,829	5,775	17,604			35
36	Other (specify):*							0				36
37	TOTAL Ownership			494,520	494,520		494,520	13,300	507,820			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					335,321	335,321	0	335,321			39
40	Barber and Beauty Shops	0	0	15,931	15,931		15,931	0	15,931			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					61,083	61,083	0	61,083			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			15,931	15,931	396,404	412,335		412,335			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,975,092	504,679	1,584,315	4,064,086	0	4,064,086	31,301	4,095,387			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(10,876)	35		5
6	Rented Facility Space	(5,580)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(547)	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(783)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(670)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,172)	24		19
20	Contributions	(500)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,088)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,778)	27		24
25	Fund Raising, Advertising and Promotional	(16,787)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,781)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	101,082		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 101,082		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 31,301		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name HERITAGE MANOR-BLOOMINGTON
IDPH 0028349
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(782)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(10,876)	35	**Line 5**	0
6	**Rented Facility Space**	(5,580)	34	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0		**Line 7**	0
8	**Laundry for Non-Patients**	0		**Line 8**	(782)
9	**Non-Straightline Depreciation**	(547)	30	**Line 9**	0
10	**Interest and Other Investment Income**	0	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0		**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0		**Line 11**	0
13	**Sales Tax**	(783)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0		**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	24	**Line 15**	0
17	**Non-Care Related Fees**	(670)	20	**Line 16**	0
18	**Fines and Penalties**	0		**Line 17**	0
19	**Entertainment**	(11,172)	24	**Line 18**	0
20	**Contributions**	(500)	27	**Line 19**	(2,000)
21	**Owner or Key-Man Insurance**	0		**Line 20**	(17,417)
22	**Special Legal Fees & Legal Retainers**	(2,088)	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0		**Line 22**	0
24	**Bad Debt**	(20,778)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(16,787)	20	**Line 24**	(11,132)
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	(21,273)
29	**Non-Paid Workers**	0	0	**Line 28**	(51,999)
30	**Donated Goods**	0	0	**Line 29**	(12,748)
31	**Amortization Expense**	0	0	**Line 30**	(547)
32				**Line 31**	0
33				**Line 32**	0
34				**Line 33**	0
35				**Line 34**	(5,580)
36				**Line 35**	(168,876)
37				**Line 36**	0
38				**Line 37**	(17,095)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(69,739)
47					
48					
49					
50					
51					
52					
53					
54					
55					
56					
57					
58					
59					
60					
61					
62					
63					
64					
65					
66					
67					
68					
69					
70					
71					
72					
73					
74					
75					
76					
77					
78					
79					
80					
81					
82					
83					
84					
85					
86					
87					
88					
89					
90					
91					
92					
93					
94					
95					
96					
97					
98					
99					
100					
101					
102					
103					
104					
105					
106					
107					
108					
109					
110					
111					
112					
113					
114					
115					
116					
117					
118					
119					
120					
121					
122					
123					
124					
125					

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	2,697	0	0	0	0	0	0	0	0	2,697	1
2	Food Purchase	(783)	0		0	0	0	0	0	0	0	0	(783)	2
3	Housekeeping	0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	939	0	0	0	0	0	0	0	0	939	5
6	Maintenance	0	0	9,542	0	0	0	0	0	0	0	0	9,542	6
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(783)	0	13,178	0	0	0	0	0	0	0	0	12,395	8
	B. Health Care and Programs													
9	Medical Director	0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(7,322)		0	181,642	0	0	0	0	0	0	174,320	10a
11	Activities	0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	2,352	0	0	0	0	0	0	0	0	2,352	13
14	Program Transportation	0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(7,322)	2,352	0	181,642	0	0	0	0	0	0	176,672	16
	C. General Administration													
17	Administrative	0	0	36,318	0	0	0	0	0	0	0	0	36,318	17
18	Directors Fees	0	0	2,756	0	0	0	0	0	0	0	0	2,756	18
19	Professional Services	(2,088)	0	8,334	0	(334,121)	0	0	0	0	0	0	(327,875)	19
20	Fees, Subscriptions & Promotions	(17,457)	0	3,500	0	0	0	0	0	0	0	0	(13,957)	20
21	Clerical & General Office Expenses	0	0	134,338	0	0	0	0	0	0	0	0	134,338	21
22	Employee Benefits & Payroll Taxes	0	0	21,186	0	0	0	0	0	0	0	0	21,186	22
23	Inservice Training & Education	0	0	1,004	0	0	0	0	0	0	0	0	1,004	23
24	Travel and Seminar	(11,172)	0	6,320	0	0	0	0	0	0	0	0	(4,852)	24
25	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,294	0	0	0	0	0	0	0	0	1,294	26
27	Other (specify):*	(21,278)	0	0	0	0	0	0	0	0	0	0	(21,278)	27
28	**TOTAL General Administration**	(51,995)	0	215,050	0	(334,121)	0	0	0	0	0	0	(171,066)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,778)	(7,322)	230,580	0	(152,479)	0	0	0	0	0	0	18,001	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(547)	0	0	6,511	0	0	0	0	0	0	0	5,964	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	(803)	0	0	0	0	0	0	0	(803)	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(5,580)	0	0	7,944	0	0	0	0	0	0	0	2,364	34
35	Rent-Equipment & Vehicles	(10,876)	0	0	16,651	0	0	0	0	0	0	0	5,775	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,003)	0	0	30,303	0	0	0	0	0	0	0	13,300	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(69,781)	(7,322)	230,580	30,303	(152,479)	0	0	0	0	0	0	31,301	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning 01/01/00 Ending 12/31/00

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V							1
2	V	10a Adjustment for Related Organizati	150,394	GreenTree Therapy	100.000%	143,072	(7,322)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 150,394			$ 143,072	$ * (7,322)	14

Sum_6

-7322

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 2,697	$ 2,697	15	2697
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				939	939	19	939
20	V	6	Maintenance				9,542	9,542	20	9542
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				2,352	2,352	26	2352
27	V	14	Program Transportatior				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				36,318	36,318	29	36318
30	V	18	Directors Fees				2,756	2,756	30	2756
31	V	19	Professional Services				8,334	8,334	31	8334
32	V	20	Fees, Subscription, Promotion				3,500	3,500	32	3500
33	V	21	Clerical & General Office Expenses				134,338	134,338	33	134338
34	V	22	Employee Benefits & Payroll Taxes				21,186	21,186	34	21186
35	V	23	Inservice Training & Education				1,004	1,004	35	1004
36	V	24	Travel and Seminar				6,320	6,320	36	6320
37	V	25	Other Admin. Staff Transportatior				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				1,294	1,294	38	1294
39	Total			$			$ 230,580	$ * 230,580	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				6,511	6,511	16	6511
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(803)	(803)	18	-803
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				7,944	7,944	20	7944
21	V	35	Rent-Equipment & Vehicles				16,651	16,651	21	16651
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 30,303	$ * 30,303	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	#REF!	$ 334,121	Heritage Enterprises, Inc.		$	$ (334,121)	15	-334121
16	V								16	
17	V	10a	#REF!	152,948	Green Tree Pharmacy	100.00%	334,590	181,642	17	181642
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 487,069			$ 334,590	$ * (152,479)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTO # 0038349 Report Period Beginnin 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Boarc	Management	0.26	18,313	10	0.20	Directors Fe	$ 919	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	0.10	18,312	10	0.20	Directors Fees	918	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	0.20	18,312	10	0.20	Directors Fees	918	line 18, col 7	3
4	Bill Froelich	Chairman of Boarc	Management	0.26	130,934	10	0.20	Salary	6,566	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	0.10	130,933	10	0.20	Salary	6,567	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	0.20	108,428	10	0.20	Salary	5,439	line 17, col 7	6
7	Joe Warner	President	Management	0.03	102,330	48	0.95	Salary	5,133	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.01	66,673	50	1.00	Salary	3,344	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.00	54,924	50	1.00	Salary	2,755	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.00	54,647	50	1.00	Salary	2,741	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.00	33,735	40	1.00	Salary	1,692	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.00	41,473	50	1.00	Salary	2,080	line 17, col 7	12
13								TOTAL	$ 39,072		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il 61701
Phone Number: (309) 823-7135
Fax Number: (309) 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,324	23	$ 56,457	$ 56,457	111	$ 2,697	1
2	2	Food Purchase	BEDS	2,324	23	6	0	111	0	2
3	3	Housekeeping	BEDS	2,324	23	0	0	111	0	3
4	4	Laundry	BEDS	2,324	23	0	0	111	0	4
5	5	Heat & Other Utilities	BEDS	2,324	23	19,665	0	111	939	5
6	6	Maintenance	BEDS	2,324	23	199,772	50,885	111	9,542	6
7	7	Other	BEDS	2,324	23	0	0	111	0	7
8	9	Medical Director	BEDS	2,324	23	0	0	111	0	8
9	10	Nursing & Medical Records	BEDS	2,324	23	0	0	111	0	9
10	11	Activities	BEDS	2,324	23	0	0	111	0	10
11	12	Social Service	BEDS	2,324	23	0	0	111	0	11
12	13	Nurse Aide Training	BEDS	2,324	23	49,237	43,081	111	2,352	12
13	14	Program Transportation	BEDS	2,324	23	0	0	111	0	13
14	15	Other	BEDS	2,324	23	0	0	111	0	14
15	17	Administrative	BEDS	2,324	23	760,393	760,393	111	36,318	15
16	18	Directors Fees	BEDS	2,324	23	57,693	0	111	2,756	16
17	19	Professional Services	BEDS	2,324	23	174,483	0	111	8,334	17
18	20	Fees, Subscription, Promotion	BEDS	2,324	23	73,288	0	111	3,500	18
19	21	Clerical & General Office Exp	BEDS	2,324	23	2,812,617	2,533,181	111	134,338	19
20	22	Employee Benefits & Payroll	BEDS	2,324	23	443,562	0	111	21,186	20
21	23	Inservice Training & Educati	BEDS	2,324	23	21,017	0	111	1,004	21
22	24	Travel and Seminar	BEDS	2,324	23	132,330	0	111	6,320	22
23	25	Other Admin. Staff Transpor	BEDS	2,324	23	0	0	111	0	23
24	26	Insurance-Prop.Liab.Malprac	BEDS	2,324	23	27,096	0	111	1,294	24
25	TOTALS					$ 4,827,616	$ 3,443,997		$ 230,580	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,324	23	$ 0	$ 0	111	$ 0	1
2	30	Depreciation	BEDS	2,324	23	136,322	0	111	6,511	2
3	31	Amortization of Pre-Op & Or	BEDS	2,324	23	0	0	111	0	3
4	32	Interest	BEDS	2,324	23	(16,821)	0	111	(803)	4
5	33	Real Estate Taxes	BEDS	2,324	23	0	0	111	0	5
6	34	Rent-Facility & Grounds	BEDS	2,324	23	166,328	0	111	7,944	6
7	35	Rent-Equipment & Vehicles	BEDS	2,324	23	348,617	0	111	16,651	7
8	36	Other	BEDS	2,324	23	0	0	111	0	8
9	38	Medically Nec Transportation	BEDS	2,324	23	0	0	111	0	9
10	39	Ancillary Service Centers	BEDS	2,324	23	0	0	111	0	10
11	40	Barber and Beauty Shops	BEDS	2,324	23	0	0	111	0	11
12	41	Coffee and Gift Shops	BEDS	2,324	23	0	0	111	0	12
13	42	Other	BEDS	2,324	23	0	0	111	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 634,446	$		$ 30,303	25

Print Previe

Print Page 8

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTO! # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle National Bank		XX	Mortage	4,640 plus Inte	01/15/99	$ 2,433,749	$ 2,297,767	01/15/06	9	$ 209,870	1
2	LaSalle Loan Amortization		XX	Mortgage							4,769	2
3	Central Office Allocation		XX	Interest Income							(803)	3
4												4
5												5
	Working Capital											
6												6
7	National City working Capital										32,442	7
8												8
9	TOTAL Facility Related						$ 2,433,749	$ 2,297,767			$ 246,278	9
	B. Non-Facility Related*											
10	Interest Income										(6,240)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,433,749	$ 2,297,767			$ 240,038	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Previe

Facility Name & ID Numbe HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	62,459	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,794	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,665)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	61,734	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	58,069	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	50,411	8
1996	53,400	9
1997	58,759	10
1998	57,580	11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Previe

Facility Name & ID Numb HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1963	$ 37,500	1
2	Nursing Home		1999	79,076	2
3	TOTALS			$ 116,576	3

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	82		1963		$ 560,548	$		$	$	$	4
5	24		1966		221,147						5
6	5		1999								6
7											7
8											8
	Improvement Type**										
9	1978 Improvements			1978	14,607						9
10	1979 Improvements			1979	95,460						10
11	1980 Improvements			1980	75,591						11
12	1981 Improvements			1981	11,544						12
13	1982 Improvements			1982	9,256						13
14	1983 Improvements			1983	13,130						14
15	1984 Improvements			1984	7,215						15
16	1985 Improvements			1985	45,885						16
17	1986 Improvements			1986	13,469						17
18	1988 Improvements			1988	83,109						18
19	1989 Improvements			1989	2,439						19
20	1990 Improvements			1990	30,676						20
21	1991 Improvements			1991	4,207						21
22	1992 Improvements			1992	1,208						22
23	1993 Improvements			1993	97,303						23
24	1994 Improvements			1994	29,638						24
25	1995 Improvements			1995	121,304						25
26	BOILER			1996	17,850						26
27	EXHAUST HOOD			1996	1,075						27
28	CODE ALERT			1996	1,852						28
29	PHONE SYSTEM			1996	2,339						29
30	INTERIOR REMODEL			1996	103,103						30
31											31
32											32
33											33
34	C/O Allocation							6,511	6,511		34
35	Book Depreciation					110,331		110,664	333	1,254,210	35
36	TOTAL (lines 4 thru 35)				$ 1563955	$ 110,331		$ 117,175	$ 6,844	$ 1,254,210	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Interior Rehab--paint, wallpaper, remodel facility			1997	211,945						9
10	Remodel Physical Therapy			1997	43,069						10
11	Disposal Unit--Kitchen			1997	1,439						11
12	Code Alert System			1997	1,997						12
13	Kitchen Remodel			1997	766						13
14											14
15	Code Alert/Nurse Call System			1998	3,654						15
16	Kitchen Remodel			1998	4,166						16
17	Remodel Physical Therapy			1998	1,813						17
18	Addition--Materials			1998	13,431						18
19	Addition--Professional Fees			1998	109,885						19
20											20
21	Addition--Materials			1999	1,155,066						21
22	Addition--Professional Fees			1999	22,035						22
23	Steam Table Hood			1999	3,821						23
24	ALTA Survey			1999	2,434						24
25	Dish Washing Area			1999	4,083						25
26	Sewage Pump			1999	2,492						26
27	Parking Lot Pavement			1999	6,743						27
28											28
29	Dayroom Light Fixtures			2000	6,189						29
30	Door Kickplates			2000	2,991						30
31	Storm windows			2000	4,011						31
32	Addition--Materials			2000	12,770						32
33	Addition--Professional Fees			2000	5,893						33
34	Roof Repair			2000	5,510						34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,626,203	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 0	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 0	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

Facility Name & ID Numbe HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 0	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 935,726	$ 73,450	$ 72,570	$ (880)		$ 681,357	37
38	Current Year Purchases	16,019						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 951,745	$ 73,450	$ 72,570	$ (880)		$ 681,357	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,258,479	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 183,781	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 189,745	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 5,964	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,935,567	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipm $ 17,604 Description: Copier, Cell Phone and Central Office Allocation
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Previe

ent

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,050		1,050
3	Classroom Wages (a)		14,903		14,903
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		2,352		2,352
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 18,305	$	$ 18,305
10	SUM OF line 9, col. 1 and 2 (e)	$ 18,305			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Previe

our
ies.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$	1,497	$ 38,316	$	1,497	$ 38,316	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs		223	10,283		223	10,283	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs		3,981	94,632	378	3,981	95,010	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				334,590		334,590	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				731			731	13
14	TOTAL			$	5,701	$ 143,962	$ 334,968	5,701	$ 478,930	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$	1
2	Cash-Patient Deposits	6,836		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	371,688		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,166		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	448,351		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 843,441	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,576		13
14	Buildings, at Historical Cost	3,132,235		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	922,506		16
17	Accumulated Depreciation (book methods)	(1,266,912)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	27,669		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,932,074	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,775,515	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 41,714	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,836		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,194		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,117		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,734		32
33	Accrued Interest Payable	23,281		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 311,876	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,297,767		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,297,767	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,609,643	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,165,872	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,775,515	$	48

***(See instructions.)**

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,008,988	1
2	Restatements (describe):		2
3	audit Adjustment	44,307	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,053,295	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	112,577	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 112,577	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,165,872	24 *

*** This must agree with page 17, line 47.**

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,109,847	1
2	Discounts and Allowances for all Levels	(500,145)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,609,702	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	241,242	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 241,242	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,003	12
13	Barber and Beauty Care	20,695	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,580	16
17	Sale of Drugs	296,399	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	891	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 325,568	23
	D. Non-Operating Revenue		
24	Contributions	151	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 151	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 4,176,663	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 829,354	31
32	Health Care	1,765,723	32
33	General Administration	958,558	33
	B. Capital Expense		
34	Ownership	494,520	34
	C. Ancillary Expense		
35	Special Cost Centers	15,931	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,064,086	40
41	**Income before Income Taxes (line 30 minus line 40)****	112,577	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ 112,577	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Previe

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,971	2,107	$ 45,137	$ 21.42	1
2	Assistant Director of Nursing	1,979	2,092	34,276	16.38	2
3	Registered Nurses	7,220	7,665	139,474	18.20	3
4	Licensed Practical Nurses	26,364	28,467	474,902	16.68	4
5	Nurse Aides & Orderlies	48,940	51,403	539,058	10.49	5
6	Nurse Aide Trainees	1,344	1,344	14,903	11.09	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,560	2,022	29,097	14.39	8
9	Activity Director					9
10	Activity Assistants	6,580	6,835	62,530	9.15	10
11	Social Service Workers	1,815	2,056	21,394	10.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,550	24,751	228,452	9.23	15
16	Dishwashers					16
17	Maintenance Workers	9,505	10,043	101,651	10.12	17
18	Housekeepers	8,997	9,264	71,996	7.77	18
19	Laundry	6,271	6,672	50,910	7.63	19
20	Administrator	2,080	2,080	59,283	28.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,042	8,670	102,029	11.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,218	165,471	$ 1,975,092 *	$ 11.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

Print Previe

0

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		9,900		36
37	Medical Records Consultant		1,250		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,982		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,444		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 15,576		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53